



Financial Assistance Application

Thank you for choosing Central Texas Rehabilitation Hospital, a Seton Family of Hospitals' partner. The Seton Healthcare Family is a Catholic healthcare ministry whose mission inspires us to care for and improve the health of those we serve with the special concern for the poor and the vulnerable. In support of our mission, we provide financial assistance to patients who cannot afford medical care.

If you are unable to pay for the medical services you receive, you can apply for financial assistance. Central Texas Rehabilitation Hospital will review your application to determine if you or your family member qualifies for governmental assistance such as Medicaid, community assistance, or financial assistance.

Financial assistance for medically necessary services is limited and is not intended to replace reasonable financial planning, health insurance coverage, or available public funding for which you may qualify.

Instructions for completing this application:

Please complete the attached Financial Assistance Application and provide the required documentation listed below. Please **do not leave any items blank!** Your application cannot be processed if the information provided is incomplete.

Your application will be evaluated according to Section 311 of the Texas Health and Safety Code as well as the guidelines set forth by section 501-R of the Affordable Care Act. We are required to determine your eligibility for assistance based upon federal poverty guidelines and all sources of income for you and your family. In some cases, we are required to consider your financial resources, assets, and non-exempt property in addition to income.

Accordingly, we require that you provide the following documentation regarding your application. Proof of income from every household member must be included before we can process the application. If you do not have a document, please indicate N/A next to the missing document. Any information received is subject to verification.

Please provide all that apply:

_____ Most recent Income Tax Return for each working family member [*Previous year's return accepted*

through April 15th]

Ex: 2015 Tax Return will be accepted through April 15th of 2017

_____ Check Stubs; **three** most recent pay periods for each working family member



_____ Letter from employer on company stationery confirming income amount stated on application

_____ Letter from unemployment office

_____ Letter from Social Security Office or copy of Social Security check

_____ Documentation on any other forms of Income; *Child Support, Alimony, Retirement Income, Trust Funds, etc.*

_____ Letter of determination for any publicly funded programs or third party payment sources; *MAP, Medicaid, Motor Vehicle Accident Liability Determination, etc.*

_____ Letter of determination for government assistance programs; *Food Stamps, WIC, Subsidized Housing, etc.*

_____ Letter of support from family member, friend, etc.

_____ Official school transcript

If you are enrolled in one of the Government Assistance programs listed on the Financial Assistance Application, you do not need to provide proof of income information other than proof of enrollment or award letters associated with the Government Assistance Program.

If you have questions or need assistance completing this form, please direct your calls as indicated below:

(512) 407- 2108

Please mail this form, along with your completed Financial Assistance Application, to the address below:

Central Texas Rehabilitation Hospital

Attn: Admissions

700 West 45th Street

Austin, TX 78751

Once all information is provided, your application will be processed and notification of the determination will be mailed to the guarantor address on file. Your Financial Assistance eligibility will be upheld for 30 days. More than 30 days past the initial application, you must reapply for any additional assistance needed. Similarly, if you are applying for financial assistance retroactively, your eligibility determination will apply to any outstanding balances.

Financial Assistance Application

Acct. #(s): _____ Acct. Balance(s): _____ MRN(s): _____

Patient Name: _____
 Social Security # _____ Date of Birth: _____ Marital Status: _____
 Guarantor: _____ Guarantor's Social Security #: _____
 Street Address: _____ Phone #: _____
 City: _____ County: _____ State: _____ Zip Code: _____

Income Information

of Dependents: _____ Number of Individuals Receiving Income: _____ Monthly Gross Wages: \$ _____
 Monthly Unemployment: \$ _____ Monthly Child Support: \$ _____ Monthly Alimony: \$ _____
 Trust Fund Receipts: \$ _____ Monthly SSI Benefits: \$ _____ Other Monthly Income: \$ _____
TOTAL MONTHLY INCOME \$ _____

SUPPORTING DOCUMENTATION MUST BE PROVIDED FOR EACH TYPE OF INCOME LISTED

Government Assistance

*Please *CHECK* all that apply*

- Food Stamps WIC (Women, Infants, and Children) Subsidized Housing
- MAP CCHC Texas Medicaid/CHIP Medicaid (a state *other than* Texas): _____
- County Indigent Care Program (county name): _____
- Seton Care Plus (SCP) Music Seton Care Plus (MSCP)

SUPPORTING DOCUMENTATION MUST BE PROVIDED FOR EACH TYPE OF ASSISTANCE CHECKED

Asset Information Section

Include all applicable values

- | | | | |
|---------------------------------|----------------|--|----------------|
| <input type="checkbox"/> Stocks | Value \$ _____ | <input type="checkbox"/> Bonds | Value \$ _____ |
| <input type="checkbox"/> IRAs | Value \$ _____ | <input type="checkbox"/> Secondary Residence | Value \$ _____ |
| <input type="checkbox"/> Boat | Value \$ _____ | <input type="checkbox"/> Collector Automobiles | Value \$ _____ |
| <input type="checkbox"/> RV | Value \$ _____ | <input type="checkbox"/> Non-Essential Automobiles | Value \$ _____ |
| | | <input type="checkbox"/> Other Luxury Items | Value \$ _____ |

TOTAL VALUE OF ASSETS \$ _____

CERTIFICATION: I certify to the best of my knowledge and believe the above information is true, correct, and complete. I understand that the information may be disclosed for uncompensated care reporting purposes.

Patient/Guarantor Signature: _____ Date: _____

Completed by: _____ Date: _____